

Schedule of benefits

If this is an ERISA plan, you may have certain rights under this plan. ERISA may not apply to a church or government group. Please contact the policyholder for additional information.

Prepared for:

| | |
|-----------------------|--------------------------------|
| Employer: | Wake Forest University |
| Contract number: | MSA-0181178 |
| Plan name: | Choice POS II High Option Plan |
| Schedule of benefits: | 1A |
| Plan effective date: | January 1, 2024 |
| Plan issue date: | March 26, 2024 |

Third Party Administrative Services provided by Aetna Life Insurance Company

Schedule of benefits

This schedule of benefits (schedule) lists the **deductibles, copayments** or **payment percentage**, if any apply to the **covered services** you receive under the plan. You should review this schedule to become aware of these and any limits that apply to these services.

How your cost share works

- The **deductibles** and **copayments**, if any, listed in the schedule below are the amounts that you pay for **covered services**.
 - For the **covered services** under your medical plan, you will be responsible for the dollar amount
 - For pharmacy benefits where a percentage cost share acts like a **copayment**, you will be responsible for the percentage amount
- **Payment percentage** amounts, if any, listed in the schedule below are what the plan will pay for **covered services**.
- Sometimes your cost share shows a combination of your dollar amount **copayment** that you will be responsible for and the **payment percentage** that your plan will pay.
- You are responsible to pay any **deductibles, copayments** and remaining **payment percentage**, if they apply and before the plan will pay for any **covered services**.
- This plan doesn't cover every health care service. You pay the full amount of any health care service you get that is not a **covered service**.
- This plan has limits for some **covered services**. For example, these could be visit, day or dollar limits. They may be:
 - Combined limits between in-network and **out-of-network providers**
 - Separate limits for in-network and **out-of-network providers**
 - Based on a rolling, 12 month period starting with the date of your most recent visit under this planSee the schedule for more information about limits.
- Your cost share may vary if the **covered service** is preventive or not. Ask your **physician** or contact us if you have a question about what your cost share will be.

For examples of how cost share and **deductible** work, go to the *Using your Aetna benefits* section under Individuals & Families at <https://www.aetna.com/>

Important note:

Covered services are subject to the **deductible**, maximum out-of-pocket, limits, **copayment** or **payment percentage** unless otherwise stated in this schedule. The *Surprise bill* section in the booklet explains your protections from a surprise bill.

Under this plan, you will:

1. Pay your **copayment**
2. Then pay any remaining **deductible**
3. Then pay your **payment percentage**

Your **copayment** does not apply to any **deductible**.

How your deductible works

The **deductible** is the amount you pay for **covered services** each year before the plan starts to pay. This is in addition to any **copayment** or **payment percentage** you pay when you get **covered services** from an in-network, **out-of-network provider**. This schedule shows the **deductible** amounts that apply to your plan. Once you have met your **deductible**, we will start sharing the cost when you get **covered services**. You will continue to pay **copayments** or **payment percentage**, if any, for **covered services** after you meet your **deductible**.

How your PCP or physician office visit cost share works

You will pay the **PCP** cost share when you get **covered services** from any **PCP**.

How your maximum out-of-pocket works

This schedule shows the **maximum out-of-pocket limits** that apply to your plan. Once you reach your **maximum out-of-pocket limit**, your plan will pay for **covered services** for the remainder of that year.

Contact us

We are here to answer questions. See the *Contact us* section in your booklet.

This schedule replaces any schedule of benefits previously in use. Keep it with your booklet.

Plan features

Deductible

You have to meet your **deductible** before this plan pays for benefits.

| Deductible type | In-network | Out-of-network |
|------------------------|-------------------|-----------------------|
| Individual | \$750 per year | \$1,875 per year |
| Family | \$1,875 per year | \$4,675 per year |

Deductible waiver

There is no in-network **deductible** for the following **covered services**:

- Preventive care
- Family planning services – female contraceptives

Cost share waiver for risk reducing breast cancer prescription drugs

The **prescription** cost share will not apply to risk reducing breast cancer **prescription** drugs when obtained at a network pharmacy. This means they will be paid at 100%.

Cost share waiver for contraceptives (birth control)

The **prescription** cost share will not apply to female contraceptive methods when obtained at a network pharmacy. This means they will be paid at 100%. This includes certain OTC and generic contraceptive **prescription** drugs and devices for each of the methods identified by the FDA. If a **generic prescription drug** is not available, the **brand-name prescription drug** for that method will be paid at 100%.

The **prescription** drug cost share will apply to **prescription** drugs that have a generic equivalent or alternative available within the same therapeutic drug class obtained at a network pharmacy unless we approve a medical exception. A therapeutic drug class is a group of drugs or medications that have a similar or identical mode of action or are used for the treatment of the same or similar disease or injury.

Cost share waiver for tobacco cessation prescription and OTC drugs

The **prescription** cost share will not apply to the first two, 90-day treatment programs for tobacco cessation **prescription** and OTC drugs when obtained at a network **retail pharmacy**. This means they will be paid at 100%. Your per **prescription** cost share will apply after those two programs have been exhausted.

Maximum out-of-pocket limit

Includes the **deductible**.

| Maximum out-of-pocket type | In-network | Out-of-network |
|-----------------------------------|-------------------|-----------------------|
| Individual | \$3,000 per year | \$7,500 per year |
| Family | \$7,500 per year | \$18,750 per year |

General coverage provisions

This section explains the **deductible**, **maximum out-of-pocket limit** and limitations listed in this schedule.

Deductible provisions

Covered services apply to the in-network and out-of-network **deductibles**.

The **deductible** may not apply to some **covered services**. You still pay the **copayment** or **payment percentage**, if any, for these **covered services**.

Individual deductible

You pay for **covered services** each year before the plan begins to pay. This individual **deductible** applies separately to you and each covered dependent. After the amount paid reaches the individual **deductible**, this plan starts to pay for **covered services** for the rest of the year.

Family deductible

You pay for **covered services** each year before the plan begins to pay. After the amount paid for **covered services** reaches this family **deductible**, this plan starts to pay for **covered services** for the rest of the year. To satisfy this family **deductible** for the rest of the year, the combined **covered services** that you and each of your covered dependents incur toward the individual **deductible** must reach this family **deductible** in a year. When this happens in a year, the individual **deductibles** for you and your covered dependents are met for the rest of the year.

Copayment

This is the dollar amount you pay for **covered services**. In most plans, you pay this after you meet your **deductible** limit. In **prescription** drug plans, it is the amount you pay for covered drugs.

Payment Percentage

This is the percentage of the bill you pay after you meet your **deductible**.

Maximum out-of-pocket limit

The **maximum out-of-pocket limit** is the most you will pay per year in **copayments**, **payment percentage** and **deductible**, if any, for **covered services**. **Covered services** that are subject to the **maximum out-of-pocket limit** include those provided under the medical plan and the outpatient **prescription** drug plan.

Covered services apply to the in-network and out-of-network **maximum out-of-pocket limit**.

Individual maximum out-of-pocket limit

- This plan may have an individual and family **maximum out-of-pocket limit**. As to the individual **maximum out-of-pocket limit**, each of you must meet your **maximum out-of-pocket limit** separately.
- After you or your covered dependents meet the individual **maximum out-of-pocket limit**, this plan will pay 100% of the eligible charge for **covered services** that would apply toward the limit for the rest of the year for that person.

Family maximum out-of-pocket limit

After you or your covered dependents meet the family **maximum out-of-pocket limit**, this plan will pay 100% of the eligible charge for **covered services** that would apply toward the limit for the remainder of the year for all covered family members. The family **maximum out-of-pocket limit** is a cumulative **maximum out-of-pocket limit** for all family members.

To satisfy this **maximum out-of-pocket limit** for the rest of the year, the following must happen:

- The family **maximum out-of-pocket limit** is met by a combination of family members
- No one person within a family will contribute more than the individual **maximum out-of-pocket limit** amount in a year

If the **maximum out-of-pocket limit** does not apply to a **covered service**, your cost share for that service will not count toward satisfying the **maximum out-of-pocket limit** amount.

Certain costs that you have do not apply toward the **maximum out-of-pocket limit**. These include:

- All costs for non-**covered services** which are identified in the booklet and the schedule
- Charges, expenses or costs in excess of the **recognized charge**
- Costs for non-emergency use of the emergency room
- Costs for non-urgent use of an urgent care **provider**

Limit provisions

Covered services will apply to the in-network and out-of-network limits.

Your financial responsibility and decisions regarding benefits

We base your financial responsibility for the cost of **covered services** on when the service or supply is provided, not when payment is made. Benefits will be pro-rated to account for treatment or portions of **stays** that occur in more than one year. Decisions regarding when benefits are covered are subject to the terms and conditions of the booklet.

Prescription drug – outpatient maximum out-of-pocket limit provisions

Covered services that are subject to the **maximum out-of-pocket limit** include **covered services** provided under the medical plan and the **prescription** drug plan.

The **maximum out-of-pocket limit** is the most you will pay per year in **copayments**, **payment percentage** and **deductible**, if any, for **covered services**. This plan may have an individual and family **maximum out-of-pocket limit**.

Covered services

Ambulance services

| Description | In-network | Out-of-network |
|------------------------|---|-------------------------|
| Emergency services | 100% per trip, no deductible applies | Paid same as in-network |
| Non-emergency services | Not covered | Not covered |

Autism spectrum disorder

| Description | In-network | Out-of-network |
|---|---|---|
| Diagnosis and testing | Contact Carolina Behavioral Health Alliance for details at 800-475-7900 | Contact Carolina Behavioral Health Alliance for details at 800-475-7900 |
| Treatment | Contact Carolina Behavioral Health Alliance for details at 800-475-7900 | Contact Carolina Behavioral Health Alliance for details at 800-475-7900 |
| Occupational (OT), physical (PT) and speech (ST) therapy for autism spectrum disorder | Covered based on type of service and where it is received | Covered based on type of service and where it is received |

Clinical trials

| Description | In-network | Out-of-network |
|---|---|---|
| Experimental or investigational therapies | Covered based on type of service and where it is received | Covered based on type of service and where it is received |
| Routine patient costs | Covered based on type of service and where it is received | Covered based on type of service and where it is received |

Durable medical equipment (DME)

| Description | In-network | Out-of-network |
|-------------|--------------------------------------|--------------------------------------|
| DME | 90% per item after deductible | 70% per item after deductible |

Emergency services

| Description | In-network | Out-of-network |
|--|---|-------------------------|
| Emergency room | \$200 then the plan pays 100% per visit, no deductible applies | Paid same as in-network |
| Non-emergency care in a hospital emergency room | Not covered | Not covered |

Emergency services important note: Out-of-network providers do not have a contract with us. However, for out of network emergencies the federal No Surprises Act applies. If the **provider** bills you for an amount above your cost share, you are not responsible for payment of that amount. You should send the bill to the address on your ID card and we will resolve any payment issue with the **provider**. Make sure the member ID is on the bill. If you are admitted to the **hospital** for an inpatient **stay** right after you visit the emergency room, you will not pay your emergency room cost share if you have one. You will pay the inpatient **hospital** cost share, if any.

Foot orthotic devices

| Description | In-network | Out-of-network |
|------------------|--------------------------------------|--------------------------------------|
| Orthotic devices | 90% per item after deductible | 70% per item after deductible |

Habilitation therapy services

Outpatient physical (PT), occupational (OT) therapies

| Description | In-network | Out-of-network |
|------------------|---|---|
| PT, OT therapies | Covered based on type of service and where it is received | Covered based on type of service and where it is received |

Outpatient speech therapy (ST)

| Description | In-network | Out-of-network |
|-------------|---|---|
| ST therapy | Covered based on type of service and where it is received | Covered based on type of service and where it is received |

Hearing aids

| Description | In-network | Out-of-network |
|---|--------------------------------------|--------------------------------------|
| Hearing aids for covered persons to age 23 | 90% per item after deductible | 70% per item after deductible |
| Limit per year Combined for in-network and out-of-network benefits | \$2,500 every 12 months | \$2,500 every 12 months |

Hearing exams

| Description | In-network | Out-of-network |
|---|---|---|
| Hearing exams for covered persons to age 23 | Covered based on type of service and where it is received | Covered based on type of service and where it is received |
| Visit limit per year | Unlimited | Unlimited |

Home health care

A visit is a period of 4 hours or less

| Description | In-network | Out-of-network |
|------------------|---------------------------------------|---------------------------------------|
| Home health care | 90% per visit after deductible | 70% per visit after deductible |

| | | |
|---|----|----|
| Visit limit per year | 40 | 40 |
| Combined for in-network and out-of-network benefits | | |

Home health care important note:

Intermittent visits are periodic and recurring visits that skilled nurses make to ensure your proper care. The intermittent requirement may be waived to allow for coverage for up to 12 hours with a daily maximum of 3 visits.

Hospice care

| Description | In-network | Out-of-network |
|--|-----------------------------|-----------------------------|
| Inpatient services - room and board | 90% after deductible | 70% after deductible |

| Description | In-network | Out-of-network |
|---------------------------------------|---|-----------------------------|
| Other inpatient services and supplies | 90% per admission after deductible | 70% after deductible |

| Description | In-network | Out-of-network |
|---------------------|---------------------------------------|---------------------------------------|
| Outpatient services | 90% per visit after deductible | 70% per visit after deductible |

| | | |
|--------------------|-----------|-----------|
| Limit per lifetime | unlimited | unlimited |
|--------------------|-----------|-----------|

Hospice important note:

This includes part-time or infrequent nursing care by an R.N. or L.P.N. to care for you up to 8 hours a day. It also includes part-time or infrequent home health aide services to care for you up to 8 hours a day.

Hospital care

| Description | In-network | Out-of-network |
|---|-----------------------------|-----------------------------|
| Inpatient services – room and board | 90% after deductible | 70% after deductible |

| Description | In-network | Out-of-network |
|--|---|-----------------------------|
| Other inpatient services and supplies | 90% per admission after deductible | 70% after deductible |

Infertility services

Basic infertility

| Description | In-network | Out-of-network |
|--|--|--|
| Treatment of basic infertility | Covered based on type of service and where it is received | Covered based on type of service and where it is received |

Comprehensive infertility services

| Description | In-network | Out-of-network |
|-------------|---------------------------------------|---------------------------------------|
| | 90% per visit after deductible | 70% per visit after deductible |

Advanced reproductive technology (ART)

| Description | In-network | Out-of-network |
|-------------|---------------------------------------|---------------------------------------|
| | 90% per visit after deductible | 70% per visit after deductible |

Limits

| Description | In-network | Out-of-network |
|--|---|---|
| Limit per lifetime ART and Comprehensive services combined | \$10,000 Combined for in-network and out-of- network benefits | \$10,000 Combined for in-network and out-of- network benefits |

Maternity and related newborn care

Includes complications

| Description | In-network | Out-of-network |
|---|---|---|
| Inpatient services – room and board | 90% per admission after deductible | 70% per admission after deductible |
| Other inpatient services and supplies | 90% per admission after deductible | 70% per admission after deductible |
| Services performed in physician or specialist office or a facility | 90% per visit after deductible | 70% per visit after deductible |
| Other services and supplies | 90% per visit after deductible | 70% per visit after deductible |

Maternity and related newborn care important note:

Any cost share collected applies only to the delivery and postpartum care services provided by an OB, GYN or OB/GYN. Review the *Maternity* section of the booklet. It will give you more information about coverage for maternity care under this plan.

Obesity surgery

| Description | In-network | Out-of-network |
|--|---|---|
| Inpatient services – room and board | 90% per admission after deductible | 70% per admission after deductible |
| Other inpatient services and supplies | 90% per admission after deductible | 70% per admission after deductible |

| Description | In-network | Out-of-network |
|---------------------|---------------------------------------|---------------------------------------|
| Outpatient services | 90% per visit after deductible | 70% per visit after deductible |

Oral and maxillofacial treatment (mouth, jaws and teeth)

| Description | In-network | Out-of-network |
|------------------------------------|---|---|
| Treatment of mouth, jaws and teeth | Covered based on type of service and where it is received | Covered based on type of service and where it is received |

Outpatient surgery

| Description | In-network | Out-of-network |
|---|---|---|
| At hospital outpatient department | 90% per visit after deductible | 70% per visit after deductible |
| At facility that is not a hospital | 90% per visit after deductible | 70% per visit after deductible |
| At the physician office | Covered based on type of service and where it is received | Covered based on type of service and where it is received |

Physician and specialist services

Physician services-general or family practitioner

Including surgical services

| Description | In-network | Out-of-network |
|--|--|---------------------------------------|
| Physician office hours (not-surgical, not preventive) | \$30 then the plan pays 100% per visit, no deductible applies | 70% per visit after deductible |

| Description | In-network | Out-of-network |
|---|---------------------------------------|---------------------------------------|
| Physician visit during inpatient stay | 90% per visit after deductible | 70% per visit after deductible |

| Description | In-network | Out-of-network |
|--|--|---------------------------------------|
| Physician telemedicine consultation | \$30 then the plan pays 100% per visit, no deductible applies | 70% per visit after deductible |

| Description | In-network | Out-of-network |
|---|--|----------------|
| Telemedicine provider consultation | \$10 then the plan pays 100% per visit, no deductible applies | Not covered |
| Basic medical services | | |

Specialist

| Description | In-network | Out-of-network |
|---|--|---------------------------------------|
| Specialist office hours (not-surgical, not preventive) | \$50 then the plan pays 100% per visit, no deductible applies | 70% per visit after deductible |

| Description | In-network | Out-of-network |
|---|---------------------------------------|---------------------------------------|
| Complex imaging, lab and radiology services during physician office visit | 90% per visit after deductible | 70% per visit after deductible |
| Complex imaging, lab and radiology services during specialist office visit | 90% per visit after deductible | 70% per visit after deductible |

| Description | In-network | Out-of-network |
|-------------------------------------|---------------------------------------|---------------------------------------|
| Physician surgical services | 90% per visit after deductible | 70% per visit after deductible |
| Specialist surgical services | 90% per visit after deductible | 70% per visit after deductible |

| Description | In-network | Out-of-network |
|--------------------------------------|---|--------------------------------|
| Specialist telemedicine consultation | \$50 then the plan pays 100% per visit, no deductible applies | 70% per visit after deductible |

All other services not shown above

| Description | In-network | Out-of-network |
|--------------------|--------------------------------|--------------------------------|
| All other services | 90% per visit after deductible | 70% per visit after deductible |

**Prescription drugs – outpatient
Maintenance Medications**

Generic prescription drugs

| Description | In-network | Out-of-network |
|--|--------------------------------|----------------|
| 30 day supply at a retail pharmacy | \$15, no deductible applies | Not covered |
| 90 day supply at a mail order pharmacy or a CVS pharmacy | \$37.50, no deductible applies | Not covered |

Preferred brand-name prescription drugs

| Description | In-network | Out-of-network |
|--|-----------------------------|----------------|
| 30 day supply at a retail pharmacy | \$30, no deductible applies | Not covered |
| 90 day supply at a mail order pharmacy or a CVS pharmacy | \$75, no deductible applies | Not covered |

Non-preferred brand-name prescription drugs

| Description | In-network | Out-of-network |
|--|------------------------------|----------------|
| 30 day supply at a retail pharmacy | \$60, no deductible applies | Not covered |
| 90 day supply at a mail order pharmacy or a CVS pharmacy | \$150, no deductible applies | Not covered |

Brand-name specialty prescription drugs

| Description | In-network | Out-of-network |
|---------------------------------------|--|----------------|
| 30 day supply at a specialty pharmacy | \$50 or 10% whichever is greater but no more than \$100, no deductible applies | Not covered |

Important note:

Your cost share for specialty prescription drugs, under the copayment assistance program, will not count toward your deductible or maximum out-of-pocket limit. This includes cost shares that you, the plan or the program pay.

Contraceptives (birth control)

Brand-name prescription drugs and devices are covered at 100% when a generic is not available

| Description | In-network | Out-of-network |
|---|--|-----------------------|
| 30 day supply of generic and OTC drugs and devices | \$0, no deductible applies | Not covered |
| 30 day supply of brand-name prescription drugs and devices | Paid based on the tier of drug in the schedule | Not covered |

Infertility drugs

| Description | In-network | Out-of-network |
|--------------------------|--|-----------------------|
| Infertility drugs | Paid based on the tier of drug in the schedule | Not covered |
| Lifetime limit | \$5,000 | Not covered |

Preventive care drugs and supplements

| Description | In-network | Out-of-network |
|---------------------------------------|--|----------------|
| Preventive care drugs and supplements | \$0, no deductible applies | Not covered |
| Limits | Subject to any sex, age, medical condition, family history and frequency guidelines as recommended by the U.S. Preventive Services Task Force (USPSTF) For a current list of covered preventive care drugs and supplements or more information, see the <i>Contact us</i> section | Not covered |

Risk reducing breast cancer prescription drugs

| Description | In-network | Out-of-network |
|---|--|----------------|
| Risk reducing breast cancer prescription drugs | \$0, no deductible applies | Not covered |
| Limits | Subject to any sex, age, medical condition, family history and frequency guidelines as recommended by the U.S. Preventive Services Task Force (USPSTF) For a current list of risk reducing breast cancer drugs or more information, see the <i>Contact us</i> section | Not covered |

Tobacco cessation prescription and OTC drugs

| Description | In-network | Out-of-network |
|---|---|----------------|
| Tobacco cessation prescription and OTC drugs | \$0, no deductible applies | Not covered |
| Limits | Subject to any sex, age, medical condition, family history and frequency guidelines in the recommendations of the USPSTF. For a current list of covered tobacco cessation drugs or more information, see the <i>Contact us</i> section. See the <i>Other services</i> section of this schedule for more information. | Not covered |

Prescription drug important note:

If you or your **provider** requests a covered **brand-name prescription drug** when a covered **generic prescription drug** equivalent is available, you will be responsible for the cost share that applies to the brand-name drug plus the cost difference between the generic drug and the brand-name drug. The cost difference does not apply toward your **prescription drug deductible** or **maximum out-of-pocket limit**.

Preventive care

| Description | In-network | Out-of-network |
|--|--|--|
| Preventive care services | 100% per visit, no deductible applies | 70% per visit after deductible |
| Breast feeding counseling and support | 100% per visit, no deductible applies | 70% per visit after deductible |
| Breast feeding counseling and support limit | 6 visits in a group or individual setting Visits that exceed the limit are covered under the physician services office visit | 6 visits in a group or individual setting Visits that exceed the limit are covered under the physician services office visit |
| Breast pump, accessories and supplies limit | Electric pump: 1 every 12 months Manual pump: 1 per pregnancy Pump supplies and accessories: 1 purchase per pregnancy if not eligible to purchase a new pump | Electric pump: 1 every 12 months Manual pump: 1 per pregnancy Pump supplies and accessories: 1 purchase per pregnancy if not eligible to purchase a new pump |
| Breast pump waiting period | Electric pump: 12 months to replace an existing electric pump | Electric pump: 12 months to replace an existing electric pump |
| Counseling for alcohol or drug misuse | 100% per visit, no deductible applies | 70% per visit after deductible |
| Counseling for alcohol or drug misuse visit limit | 5 visits/year | 5 visits/year |
| Counseling for obesity, healthy diet | 100% per visit, no deductible applies | 70% per visit after deductible |
| Counseling for obesity, healthy diet visit limit | Age 22 and older: 26 visits per year, of which up to 10 visits may be used for healthy diet counseling. | Age 22 and older: 26 visits per year, of which up to 10 visits may be used for healthy diet counseling. |
| Counseling for sexually transmitted infection | 100% per visit, no deductible applies | 70% per visit after deductible |
| Counseling for sexually transmitted infection visit limit | 2 visits/year | 2 visits/year |
| Counseling for tobacco cessation | 100% per visit, no deductible applies | 70% per visit after deductible |
| Counseling for tobacco cessation visit limit | 8 visits/year | 8 visits/year |
| Family planning services (female contraception counseling) | 100% per visit, no deductible applies | 70% per visit after deductible |
| Family planning services (female contraception counseling) limit | Contraceptive counseling limited to 2 visits/year in a group or individual setting Counseling that exceeds this limit covered as a physician services office visit | Contraceptive counseling limited to 2 visits/year in a group or individual setting Counseling that exceeds this limit are covered as a physician services office visit |

| | | |
|-------------------------------------|---|---|
| Immunizations | 100%, no deductible applies | 70% after deductible |
| Immunizations limit | Subject to any age limits provided for in the comprehensive guidelines supported by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention For details, contact your physician | Subject to any age limits provided for in the comprehensive guidelines supported by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention For details, contact your physician |
| Routine cancer screenings | 100% per visit, no deductible applies | 70% per visit after deductible |
| Routine cancer screening limits | Subject to any age, family history and frequency guidelines as set forth in the most current: Evidence-based items that have a rating of A or B in the current recommendations of the USPSTF The comprehensive guidelines supported by the Health Resources and Services Administration For more information contact your physician or see the <i>Contact us</i> section | Subject to any age, family history and frequency guidelines as set forth in the most current: Evidence-based items that have a rating of A or B in the current recommendations of the USPSTF The comprehensive guidelines supported by the Health Resources and Services Administration For more information contact your physician or see the <i>Contact us</i> section |
| Routine lung cancer screening | 100% per visit, no deductible applies | 70% per visit after deductible |
| Routine lung cancer screening limit | 1 screening per year Screenings that exceed this limit covered as outpatient diagnostic testing | 1 screening per year Screenings that exceed this limit covered as outpatient diagnostic testing |
| Routine physical exam | 100% per visit, no deductible applies | 70% per visit after deductible |
| Routine physical exam limits | Subject to any age and visit limits provided for in the comprehensive guidelines supported by the American Academy of Pediatrics/Bright Futures/Health Resources and Services Administration for children and adolescents Limited to 7 exams from age 0-1 year; 3 exams every 12 months age 1-2; 3 exams every 12 months age 2-3; and 1 exam per year after that age, up to age 22; 1 exam per year after age 22 High risk Human Papillomavirus (HPV) DNA testing for woman age 30 and older limited to 1 every 36 months | Subject to any age and visit limits provided for in the comprehensive guidelines supported by the American Academy of Pediatrics/Bright Futures/Health Resources and Services Administration for children and adolescents Limited to 7 exams from age 0-1 year; 3 exams every 12 months age 1-2; 3 exams every 12 months age 2-3; and 1 exam per year after that age, up to age 22; 1 exam per year after age 22 High risk Human Papillomavirus (HPV) DNA testing for woman age 30 and older limited to 1 every 36 months |

| | | |
|---------------------------|--|--|
| Well woman GYN exam | 100% per visit, no deductible applies | 70% per visit after deductible |
| Well woman GYN exam limit | Subject to any age and visit limits provided for in the comprehensive guidelines supported by the Health Resources and Services Administration | Subject to any age and visit limits provided for in the comprehensive guidelines supported by the Health Resources and Services Administration |

Prosthetic devices

| Description | In-network | Out-of-network |
|--------------------|---|---|
| Prosthetic devices | Covered based on type of service and where it is received | Covered based on type of service and where it is received |

Reconstructive surgery and supplies

Including breast **surgery**

| Description | In-network | Out-of-network |
|-----------------------------|---|---|
| Surgery and supplies | Covered based on type of service and where it is received | Covered based on type of service and where it is received |

Short-term rehabilitation services

A visit is equal to no more than 1 hour of therapy.

Cardiac rehabilitation

| Description | In-network | Out-of-network |
|------------------------|---|---|
| Cardiac rehabilitation | Covered based on type of service and where it is received | Covered based on type of service and where it is received |

Pulmonary rehabilitation

| Description | In-network | Out-of-network |
|--------------------------|---|---|
| Pulmonary rehabilitation | Covered based on type of service and where it is received | Covered based on type of service and where it is received |

Cognitive rehabilitation

| Description | In-network | Out-of-network |
|--------------------------|---|---|
| Cognitive rehabilitation | Covered based on type of service and where it is received | Covered based on type of service and where it is received |

Physical and occupational therapies

| Description | In-network | Out-of-network |
|-------------|---------------------------------------|---------------------------------------|
| | 90% per visit after deductible | 70% per visit after deductible |

Speech therapy (ST)

| Description | In-network | Out-of-network |
|-------------|---------------------------------------|---------------------------------------|
| | 90% per visit after deductible | 70% per visit after deductible |

Physical and occupational therapies

| Description | In-network | Out-of-network |
|---|------------|----------------|
| Visit limit per year | 60 | 60 |
| Combined for in-network and out-of-network benefits | | |

Speech Therapy (ST)

| Description | In-network | Out-of-network |
|---|------------|----------------|
| Visit limit per year | 20 | 20 |
| Combined for in-network and out-of-network benefits | | |

Spinal manipulation

| Description | In-network | Out-of-network |
|---------------------------------|---------------------------------------|---------------------------------------|
| Includes x-rays and evaluations | 90% per visit after deductible | 70% per visit after deductible |

| | | |
|---|---------|---------|
| Maximum limit per year | \$1,000 | \$1,000 |
| Combined for in-network and out-of-network benefits | | |

Skilled nursing facility

| Description | In-network | Out-of-network |
|--|---|---|
| Inpatient services - room and board | 90% per admission after deductible | 70% per admission after deductible |
| Other inpatient services and supplies | 90% per admission after deductible | 70% per admission after deductible |

| | | |
|---|----|----|
| Day limit per year | 90 | 90 |
| Combined for in-network and out-of-network benefits | | |

Tests, images and labs – outpatient

Diagnostic complex imaging services

| Description | In-network | Out-of-network |
|-------------|---------------------------------------|---------------------------------------|
| | 90% per visit after deductible | 70% per visit after deductible |

Diagnostic lab work

| Description | In-network | Out-of-network |
|---|--|---------------------------------------|
| At facility that is not a hospital (Independent lab) | 100% per visit, no deductible applies | 70% per visit after deductible |
| At hospital outpatient department | 90% per visit after deductible | 70% per visit after deductible |

Diagnostic x-ray and other radiological services

| Description | In-network | Out-of-network |
|-------------|---------------------------------------|---------------------------------------|
| | 90% per visit after deductible | 70% per visit after deductible |

Therapies

Chemotherapy

| Description | In-network | Out-of-network |
|-----------------------|---|---|
| Chemotherapy services | Covered based on type of service and where it is received | Covered based on type of service and where it is received |

Gene-based, cellular and other innovative therapies (GCIT)

| Description | In-network (GCIT-designated facility/provider) | Out-of-network (Including providers who are otherwise part of Aetna's network but are not GCIT-designated facilities/ providers) |
|--|--|--|
| Services and supplies | Covered based on type of service and where it is received | Not covered |
| Gene therapy products, prescription drugs | \$50 then the plan pays 100% per visit after deductible | Not covered |

Infusion therapy

Outpatient services

| Description | In-network | Out-of-network |
|-------------|---------------------------------------|---------------------------------------|
| | 90% per visit after deductible | 70% per visit after deductible |

Radiation therapy

| Description | In-network | Out-of-network |
|-------------------|---|---|
| Radiation therapy | Covered based on type of service and where it is received | Covered based on type of service and where it is received |

Respiratory therapy

| Description | In-network | Out-of-network |
|---------------------|---|---|
| Respiratory therapy | Covered based on type of service and where it is received | Covered based on type of service and where it is received |

Transplant services

| Description | In-network (IOE facility) | Out-of-network (Includes providers who are otherwise part of Aetna's network but are non-IOE providers) |
|---------------------------------|---|---|
| Inpatient services and supplies | 90% per transplant after deductible | 70% per transplant after deductible |
| Physician services | Covered based on type of service and where it is received | Covered based on type of service and where it is received |

Urgent care services

At a freestanding facility or **provider** that is not a **hospital**

A separate urgent care cost share will apply for each visit to an urgent care facility or **provider**

| Description | In-network | Out-of-network |
|--|--|--|
| Urgent care facility | \$50 then the plan pays 100% per visit, no deductible applies | \$50 then the plan pays 100% per visit, no deductible applies |
| Non-urgent use of an urgent care facility or provider | Not covered | Not covered |

Vision care

Performed by an ophthalmologist or optometrist and includes refraction

| Description | In-network | Out-of-network |
|-------------|--|----------------|
| | \$30 then the plan pays 100% per visit, no deductible applies | Not covered |

| | | |
|-------------|------------------|----------------|
| Visit limit | 1 visit per year | Not applicable |
|-------------|------------------|----------------|

Walk-in clinic

Not all preventive care services are available at a **walk-in clinic**. All services are available from a network **physician**.

| Description | Designated network | Non-designated network | Out-of-network |
|--|--|--|--|
| Non-emergency services | 100% per visit, no deductible applies | \$30 then the plan pays 100% per visit, no deductible applies | 70% per visit after deductible |
| Preventive care immunizations | 100% per visit, no deductible applies | 100% per visit, no deductible applies | 70% per visit after deductible |
| Preventive care immunization limits | Subject to any age and frequency limits provided for in the comprehensive guidelines supported by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention For details, contact your physician | Subject to any age and frequency limits provided for in the comprehensive guidelines supported by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention For details, contact your physician | Subject to any age and frequency limits provided for in the comprehensive guidelines supported by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention For details, contact your physician |
| Preventive screening and counseling services | 100% per visit, no deductible applies | 100% per visit, no deductible applies | 70% per visit after deductible |
| Preventive screening and counseling limits | See the <i>Preventive care services</i> section of the schedule | See the <i>Preventive care services</i> section of the schedule | See the <i>Preventive care services</i> section of the schedule |

| Description | Designated network | Non-designated network | Out-of-network |
|---|---|---|----------------|
| Telemedicine consultation for non-emergency services through a walk-in clinic | 100% per visit no deductible applies | Covered based on type of service and where it is received | Not covered |
| Telemedicine consultation for preventive screening and counseling services through a walk-in clinic | 100% per visit no deductible applies | Covered based on type of service and where it is received | Not covered |

Important note:

Key terms

Designated network provider

A **network provider** listed in the directory under *Best results for your plan* as a **provider** for your plan.

Non-designated network provider

A **provider** listed in the directory under the *All other results* tab as a **provider** for your plan.

See the *Contact us* section if you have questions.

You will pay less cost share when you use a designated network **walk-in clinic provider**. Non-designated network **walk-in clinic providers** are available to you, but the cost share will be at a higher level when these **providers** are used.